South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive, P.O. Box 11289
Columbia, South Carolina 29211
(803) 896-4500

APPLICATION FOR A VOLUNTEER LIMITED LICENSE

NOTE: Application must be fully completed with all requested information and documentation supplied.

I hereby make application to the State Board of Medical Examiners of South Carolina for a Special Volunteer Limited License in the State of South Carolina and submit the following statement of facts with the required supporting documents. *The application form itself is a public document obtainable under the Freedom of Information Act.*

I. PERSONAL DATA

Applicant's Name _____
Last First Middle

Home Address:

_____
Street address

_____
City State Zip

(_____)_____
Home telephone number

_____
Medical training/Specialty

Expected practice location:

_____
Hospital/Clinic

_____
Street address

_____
City State Zip

(_____)_____
Office telephone number

_____ _____ (_____)_____
Supervising Physician name SC License Number Supervising physician telephone number

_____ _____
Address City, State, Zip

List all states in which you have been licensed, active or inactive:

State	Date of Licensure	Basis of Licensure (USMLE, NB, FLEX)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Military service: Branch _____ Dates of Service _____
_____ Type of Discharge _____ (Attach copy)

Current medical specialty _____

If certified by an ABMS or AOA Board, supply name of Board _____

Date of most recent certification/recertification _____

Revised 7/10/12

I. PERSONAL DATA (Cont'd)

Answer Yes or No

1. Has your medical license ever been revoked, suspended, reprimanded, restricted or placed on probation by a medical licensing board or other entity? _____

2. Have you ever had an application to practice medicine denied or refused by another medical licensing board or entity? _____

3. Have you ever had any hospital privileges denied, revoked, suspended, or restricted in any way? _____

4. Have you ever voluntarily surrendered a medical license, controlled substance registration or DEA registration? _____

5. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action? _____

6. Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, health care facility or other entity? _____

7. Is your medical license currently restricted in any way by any medical licensing board, or other entity? _____

8. Have you ever had a malpractice lawsuit, judgment or settlement filed against you? If so, how many? _____ _____

9. Currently or within the last ten years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician? _____

10. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as a physician? _____

11. Has your ability to practice medicine ever been impaired by any physical or mental illness or by the use of alcohol or drugs? _____

12. Have you ever discontinued the practice of medicine for any reason for one month or more? _____

13. Has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity? _____

14. Currently or within the last ten years, have you been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state, or local law (other than a minor traffic violation)? _____

15. Have you ever been known by any other name or surname? _____

NOTE: If you answered "Yes" to any of the above questions (1-15), you must attach a full written explanation pertaining to that particular question.

II. MEDICAL EDUCATION

Name of College/University_____ Location _____

Dates of attendance from _____to_____ Degree _____

1. List below all medical schools attended and specific dates of attendance:

School	Location	From Mo., Day, Yr.	To Mo., Day, Yr.	Number Yrs. Attended
_____	_____	from _____	to _____	_____
_____	_____	from _____	to _____	_____

2. (M.D.) (D.O.) Degree from _____Date _____
   Location (city, state & country) of medical school _____

3. Internship or residency training (anticipated or completed) as follows:
   Internship at _____ from _____to _____
   Residency in _____ from _____ to _____
   Residency in _____ from _____ to _____
   Fellowship in _____ from _____ to _____

III. MEDICAL PRACTICE HISTORY

List all activities chronologically since postgraduate training. Vacation periods and periods when medicine was not practiced must be included. (Use additional sheets of paper if necessary)

From Month / Year	To Month / Year	Office Address & Location	Type of Practice
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IV. AFFIDAVIT

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice medicine in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board or its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every kind of arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements by me herein are true and correct. Should I furnish any false or incorrect information on this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice medicine in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards, and to federal and state entities, as required by law.

RIGHT THUMB PRINT

If right thumb is missing, use left and so indicate

_____
Signature of Applicant

_____
Date

Subscribed and sworn before me this _____ day of _____, _____

_____(L.S.)
Signature of Notary Public

_____
My Commission Expires

SEAL

PHOTOGRAPH

Note: A recent portrait type photograph must be pasted here. Photograph must be passport size to 3" x 5".

(Please, no copies)

GENERAL INFORMATION

Date of Birth _____

Place of Birth _____

Sex _____ Race _____

Height _____ Weight _____

Marital Status _____

Dependents (other than myself)

_____

_____

_____

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state medical boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things.

AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
   b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   a. ___ I am a US citizen, not physically present or employed in the United States.
   b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided.

☐ Any valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card? Number _____; Date of Expiration: _____

☐ Any valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit? State: _____; Number_____; Date of Expiration: _____.

☐ Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.

☐ Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____

☐ Certificate of Naturalization with intact photo.

☐ Certificate of (US) Citizenship with intact photo.

☐ Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where this secure and verifiable document was issued.

_____

(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.

_____ _____

Signature Date

_____

Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

South Carolina Department of Labor Licensing & Regulation
Board of Medical Examiners
110 Centerview Drive, P.O. Box 11289
Columbia, SC 29211
(803) 896-4500
Fax: (803) 896-4515

Applicant's Name _____
First Middle Last

I am applying for a license to practice medicine in the state of South Carolina. Please complete this form and forward an original graduate transcript bearing the institution's official seal to the address listed above.

_____ _____
Applicant's Signature Date

CERTIFICATION OF MEDICAL OR OSTEOPATHIC EDUCATION

(Medical School is requested to complete this insert with the school seal and send copies of medical school transcript certified by the medical school to South Carolina Board of Medical Examiners.)

It is hereby certified that _____

of (hometown, state and country) _____

attended (full name of school) _____

from _____ to _____ and received a diploma conferring the

degree of _____ and said diploma bears the

following date _____.

A certified copy of this applicant's transcripts is enclosed.

(SEAL)

Current Date _____ _____
(Dean, Registrar, President)

South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive, P.O. Box 11289
Columbia, South Carolina 29211
(803) 896-4500

81-75. Waiver of Fees and Special Volunteer License

The fundamental purpose of the State Board of Medical Examiners is to protect the public. This is accomplished by insuring that only competent, qualified physicians are licensed to practice medicine in South Carolina. Such public protection is best afforded by a permanent, unrestricted license to practice medicine in South Carolina.

The State Board of Medical Examiners wishes to remove any financial impediments that might inhibit physicians otherwise eligible for unrestricted licensure from providing medical services to the indigent and needy citizens of our State. Therefore, this Board shall waive all application fees, examination fees and annual reregistration fees for any physician who otherwise meets all permanent licensure requirements if the physician documents, to the satisfaction of the Board, that his practice is to be exclusively and totally devoted to providing medical care to the needy and indigent in South Carolina. To be eligible for the waiver of such fees, a physician must acknowledge that there shall be no expectation of payment or compensation for any medical services rendered, or any compensation or payment to the physician, either direct or indirect, monetary or in-kind, for the provision of medical services.

The Board also hereby establishes a Special Volunteer License for physicians meeting the requirements for such license. This License shall be issued for a fiscal year, or a part thereof, renewable annually upon approval by the Board. It will limit practice to a specific site(s) and practice setting(s). There will be no licensure or other fees associated with this Special Volunteer License. Requirements for this Special Volunteer License shall be as follows:

1. Satisfactory completion of a Special Volunteer License Application, including documentation of medical/osteopathic school graduation and practice history;

2. Documentation of specific proposed practice location(s);

3. Documentation that applicant has been previously issued an unrestricted license to practice medicine in another state of the United States and that applicant has never been the subject of any disciplinary action in any jurisdiction;

4. Documentation that the applicant shall only practice under the supervision of a supervising physician(s) approved by the Board. In order to insure that public health, safety and welfare are protected, the Board will review the proposed supervisory relationship to insure that the physician supervisor(s) is competent to supervise the Special Volunteer Licensee. Factors the Board shall consider will include, but not be limited to the training and practice experience of the supervising physician, the current nature and extent of the supervising physician's practice, the existence of any recent demonstration of the supervising physician's clinical competency and the number of Special Volunteer Licensees the physician proposes to supervise.

5. Documentation of the name(s) of supervising physician(s) and that such physician(s) has agreed to accept this supervisory responsibility. All supervising physicians must possess an active, unrestricted permanent license to practice medicine in South Carolina. An approved supervising physician must physically be on the premises whenever a Special Volunteer Licensee is practicing medicine.

6. Documentation and acknowledgement that the applicant shall receive no payment or compensation, either direct or indirect or have any expectation of payment or compensation for medical services rendered. Moreover, the supervising physician shall not receive any compensation or payment as the result of the Special Volunteer Licensee's provision of medical services.

South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive, P.O. Box 11289
Columbia, South Carolina 29211
(803) 896-4500

MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

_____

Name of physician Office telephone no.

_____

Address City State Zip

MALPRACTICE COMPLAINT: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)

Patient's Name: _____

Age: _____ Sex: _____

Date/place of Occurrence:_____

Indicate your position in case, i.e., resident, primary physician, etc.: _____

_____

_____

FILED AGAINST: ( ) Individual Doctor ( ) Group ( ) Hospital

List names of other defendant-doctors and/or hospitals:

_____

_____

DISPOSITION: ( ) Pending ( ) Jury Verdict ( ) Settled ( ) Dismissed ( ) Dropped

If there has been a verdict or settlement, please provide the following information:

Legal Outcome: _____

Total Amt.
Date: _____Paid (if Any): _____

Amount attributable to you: _____

1. **On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.**
2. **Provide the Board with copies of the complaint, answer, release, settlement documents and all other relevant legal documents.**
3. **Form may be duplicated as needed. A separate report must be completed for each malpractice claim.**

Date: _____ Signature: _____

VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever been licensed to practice medicine. You may want to contact each state to see if a fee is required.

Dear Sir:
In applying for a license to practice medicine (or osteopathy) in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My Signature below is you authority to release any and all information in your file, favorable or otherwise regarding myself, directly to:

SC Dept. Of Labor, Licensing and Regulation
Board of Medical Examiners
P.O. Box 11289
Columbia, SC 29211
(803) 896-4500
Fax (803) 896-4515

PLEASE TYPE OR PRINT

Signature _____

Name _____

Address _____

_____
City State Zip

DO NOT DETACH

This section should be complete by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: _____

Graduate of: _____Date of degree: _____

State of: _____ License number: _____ Date issued: _____

Licensed by: ( ) National Board ( ) FLEX Exam ( ) USMLE
( ) State Board Exam ( ) Other_____

License is current_____ If no, why not? _____

Has license been suspended, revoked, or restricted? _____ If yes, why? _____

Has licentiate ever been requested to appear before your Board?_____ If yes, why?_____

_____

Derogatory information, if any_____

Comments, if any_____

_____

Signature: _____

Board Seal Title: _____

Date: _____ State Board: _____

Special Limited Licensee Name_____ (Please type or print clearly)

TO BE COMPLETED BY PROPOSED SUPERVISING PHYSICIAN

(Please type or print clearly) SC License Number:_____

Name:_____
First Middle Last name

Address:_____

City:_____State:_____Zip:_____

Home telephone: ( )_____Office telephone: ( )_____

1. Type of Practice/Specialty of Supervising Physician: _____

2. Are you Board Certified by an ABMS or AOA Specialty Board?_____ If so, provide name of specialty board and date of most recent Board certification/recertification _____

3. Summary of your Medical Practice History: (List all medical activities chronologically since post graduate training)

From Month/Yr.	To Month/Yr.	Office Address	Type of Practice
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- I acknowledge and agree, if approved by the Board, that I shall be responsible for supervising the Special Volunteer Licensee named in this application.

- I further acknowledge that this Special Volunteer Licensee shall be permitted to practice medicine only when I, or another supervising physician approved by the Board, am physically present with this licensee.

- I agree that should I become aware of any unethical, unprofessional or illegal acts or omissions on the part of the Special Volunteer Licensee, or any acts or omissions that violate the terms and conditions of the Special Volunteer License, I shall immediately report such conduct in writing to the State Board of Medical Examiners of South Carolina.

- I understand that the Special Volunteer Licensee is not to receive any compensation or payment, direct or indirect for the rendering of medical services, and that I shall receive no payment or compensation resulting from the Special Volunteer Licensee's provision of medical services.

_____ _____ _____
(Date) (Signature) (S. C. License Number)

American Medical Association

Physicians dedicated to the health of America

AMA Physician Profile Unit
515 North State Street
Chicago, IL 60610

Telephone: 312 464-5199
Fax: 312 464-5900

This Form is for Physician Use Only.

Complete and send this form to the American Medical Association (AMA) at the above address. Profiles also can be ordered online through **AMA ePhysician Profiles** located at http://www.ama-assn.org/AMAPhysicianProfiles. AMA Customer Service is available for ordering assistance at 800 665-2882 or 312 464-5199, Monday through Friday, 8:30 am – 4:45pm CT.

Join or renew your AMA membership today---call 800 AMA-3211

Indicate AMA Membership Status: _____Member Physician _____Nonmember Physician

Membership Type	**Standard Mail Service*** (within 10 business days)	**Express Service*** (within 5 business days)
AMA Member Physician	No Charge	$6 per profile
Nonmember Physician	$26 per profile	Not available

***Prices are subject to change without advance notice.**

Credit card payment is preferred as check payments may extend processing time. Checks should be made payable to the American Medical Association, Remittance Control Area/PPS, Accounting Department, PO Box 109054, Chicago, IL 6061l0. Orders faxed to the AMA must include credit card information for billing purposes.

_____VISA _____American Express ____MasterCard Charge Amount**: $**_____

Credit Card Number _____ Expiration ____/____/_____

Name on Credit Card: _____

Billing Address: _____

*Approval Signature*_____ *Daytime Telephone:*_____

Part 1: State Licensing Board Information

Please send my profile to the following state licensing or medical specialty board:

Board Name _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

_____
Physician Name (first, middle, last, suffix)

_____ / / _____
Place of Birth Date of birth Social Security #

_____ _____
E-mail Address Medical Education Number (optional)

_____
Preferred Mailing Address

_____(_____)_____-_____
City State Zip Code Telephone Number

The above address is my OFFICE ___ HOME ____ OTHER _____

If address is home or other...please complete this section.

_____
Primary Office Address

_____(_____)_____-_____
City State Zip Code Office Telephone Number

Part 3: Medical Education and Other Information

_____ _____
Medical School of Graduation Year of Graduation

_____ _____
DEA # ECFMG #

Residency Training

_____
Residency Training (institution/hospital name, location, and years)

_____

_____

Hospital Admitting Privileges

_____ _____
Hospital Name City/ State

_____ _____

_____ _____

_____ _____

Group Practice Affiliation(s)

_____ _____
Group Practice Name City/ State

_____ _____

_____ _____

Physician Agreement

Agreement must be signed in order to process your request.
AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X_____ _____/_____/_____
Signature Date

(7/10/12 Rev)